Dermatology Specialists of Spokane

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MEDICAL RECORD RELEASE FORM

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email Address: _____

☐ Send Medical Information from our office ☐ Obtain Medical Information from an outside

_____

Name of Person or Entity to Receive / Release Information *

_____

Title (Physician, Therapist, Attorney, etc.) *

_____

Street Address, City, State, Zip Code *

_____

Phone Number * Fax Number *

☐ All Records ☐ Specific Date Range _____ to _____

☐ Specific Report(s) _____

* I understand that I do not have to sign this authorization of release in order to receive treatment from ***Dermatology Specialists of Spokane***. In fact, I have the right to refuse to sign this authorization of release. When my information is used or disclosed pursuant of this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization of release in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation of this release must be submitted to ***Dermatology Specialists of Spokane***.

_____

Patient Signature (Parent or Guardian if minor) Date

_____

Dermatology Specialists of Spokane Team Member Signature Date